STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395330	A. BLDG: __00_____ B. WING: _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHELTENHAM NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **032202**	**600 WEST CHELTENHAM AVENUE PHILADELPHIA, PA 19126**

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F 0000	INITIAL COMMENT	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE: (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0000	Continued from page 1 Based on a Medicare/Medicaid Recertification Survey, State Licensure Survey, Civil Rights Compliance Survey and an Abbreviated Survey in response to a complaint and reportable incident, completed on March 31, 2023, it was determined that Cheltenham Nursing and Rehabilitation Center was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations as they relate to the Health portion of the survey process.	F 0000		

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F 0000	Continued from page 2	F 0000		
F 0656 SS=D		F 0656		

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F 0656 SS=D	Continued from page 3 483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future	F 0656	Preparation and submission of this plan is required by state and federal law. This plan of correction does not constitute an admission for the purposes of general liability, professional malpractice, or other court proceedings. The plan of correction constitutes our credible allegation of compliance. 1. On 3/30/2023 Director of Nursing or Unit Manager revised the care plans for Resident R141 and Resident R154.On 4/20/2023 a behavior contract was initiated for Resident R141 and Resident R154. NHA reviewed transportation logs and interviewed Resident R141, and she confirmed that she has never been out on an outside doctor's appointment without an escort. 2. On 3/30/2023, the nursing leadership team reviewed the electronic health record for all residents with a substance use disorder diagnosis to determine if a person-centered care plan was present. 3. On 4/6/2023, the nurse educator	Completion Date: **05/08/2023** Status: **APPROVED** Date: **04/24/2023**

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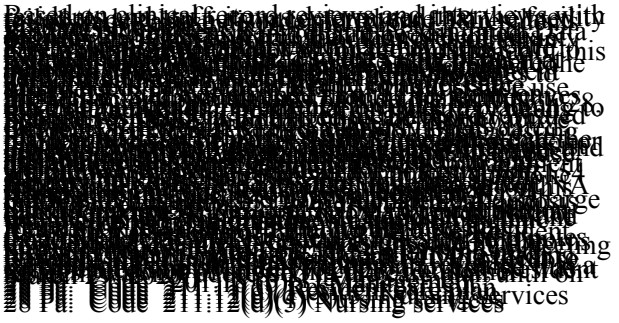
F 0656 SS=D	Continued from page 4 discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: 	F 0656	educated the nursing team and IDT team on developing and implementing person-centered comprehensive care plans for residents. 4. The DON, NHA, and/or designee will complete weekly audits of care plans relating to substance use disorder. for 4 weeks, monthly audits for 2 months and quarterly audits for 2 quarters. Results of the audits will be reviewed at the Quality Assurance Performance Improvement meeting to determine need for additional audits.	

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F 0684 SS=D		F 0684		

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F 0684 SS=D	Continued from page 6 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	1. On March 30,2023 Resident R5 was assessed by the unit manager and there were no negative findings as a result of the omission of Heparin; Humalog or. Sevelamer. On March 30, 2023, the Director of Nursing obtained an order from Resident R5's physician to change the administration times of the three medications. The physician was notified of the omission on 3/30/2023 by the DON. On 3/29/2023 Resident R108 was assessed by the Unit Manager. Resident R108's leg was cleaned treated, and a dressing was applied to the affected area. 2. On March 30, 2023, the nursing team reviewed the electronic health record of all residents that attend dialysis to determine if medication administration times conflicted with dialysis treatment times. On 3/30/2023, the nursing team reviewed the TAR for all residents receiving wound care to determine if treatments were being administered per physician orders. 3. On, 4/6/2023 the nursing team and	Completion Date: **05/08/2023** Status: **APPROVED** Date: **04/24/2023**

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F 0684 SS=D	Continued from page 7	F 0684	IDT team were educated by the DON on administering medications as ordered by the physician and following physician orders for skin care. 4. The DON, NHA, and/or designee will conduct random audits of physician orders weekly audits for 4 weeks, monthly audits for 2 months and quarterly audits for 2 quarters. Results of the audits will be reviewed at the Quality Assurance Performance Improvement meeting to determine need for additional audits.	

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F 0684 SS=D	Continued from page 8 Based on observations, clinical record reviews and interviews with staff, it was determined that facility failed to administer medications as ordered by the physician and failed to follow physician orders for skin care for two of 38 residents reviewed. (Resident R5 and Resident R108) Findings include: Review of Resident R5's annual comprehensive Minimum data Set (MDS-assessment of resident's care needs) assessment dated February 24, 2023 indicated that the resident had diagnoses of end stage renal disease and diabetes mellitus (failure of the body to produce insulin) and deep venous thrombosis (the formation or presence of a blood clot in a blood vessel).	F 0684		

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F 0684 SS=D	Continued from page 9 Interview with the Licensed nurse, Employee E27 on March 30, 2023 at 2:00 p.m. revealed that Resident R5 was ordered hemodialysis treatments at an outside dialysis clinic three days a week (Tuesday, Thursday, Saturday). Licensed nurse, Employee E27 reported that the resident was out of the facility from 10:00 a,m. until 2:00 p.m., on hemodialysis treatment days. The licensed nurse reported that the food and nutrition department provides a lunch for this resident to take to the dialysis center. Review of Resident R5's March 2022 physican orders revealed an order for Heparin 1 milliliter injection subcutaneously every 8 hours for acute embolism and thrombosis, Humalog (lispro insulin) 10 units, before meals for	F 0684		

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F 0684 SS=D	Continued from page 10 diabetes mellitus and Sevelamar carbonate (a medication used to lower phosphorus in the blood) 800 mg 1 tablet by mouth with meals. Review of Resident R5's march Treatment Administration Record (TAR) revealed that the 1:00 p.m., dose of Heparin was not administered on March 2, 4, 7, 9, 11, 14, 16, 18, 21 and 28. Further there was no documentation to indicate that the nursing staff notified the physician for clarification of the medication order on these dates and times of administration. Continued review of Resident R5's March TAR revealed that the 12 noon dose of Humalog was omitted on March 2, 4, 7, 9, 11, 14, 16, 18, 21, 23, 25, 28 and 30, 2023. There was no documentation to	F 0684		

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F 0684 SS=D	Continued from page 11 indicate that the nursing staff notified the physician for clarification of the medication order on these dates and times of administration. Further the noon dose of medication was omitted on March 2, 4, 7, 9, 11, 21, 23, 28 and 30 2023. There was no documentation to indicate that the nursing staff notified the physician for clarification of the medication order on these dates and times of administration. Interview with the Director of Nursing, on March 30, 2023 at 2:15 p.m. confirmed the omission of the medications for Resident R5 during the month of March, 2023. The Director of Nursing also confirmed that there was no clarification obtained related to the medication orders and day and time of administration.	F 0684		

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F 0684 SS=D	Continued from page 12 Review of physician orders for Resident R108 dated September 15, 2022 revealed an order to cleanse right lower extremity with 15ml hibiclens (antimicrobial skin cleanser) with 50 ml of normal saline solution, dry, and apply honey, 4 inch x 4 inch dressing , ABD pad (used absorb heavy drainage) and wrap leg with kling(absorbent gauze roll). every 8 hours as needed related to excoriation. Review of Medication Administration for Resident R108 for the month of March 2023 revealed that the above order was not administered for the month of March. Observation of Resident R108 on March 27, 2023 at 10:27 a.m. revealed that there were multiple dried scabs and actively bleeding areas on the resident's right leg.	F 0684		

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F 0684 SS=D	Continued from page 13 There was no dressing or treatment observed this area. A heel boot in resident's room was also noted with dried blood. During an interview Resident R108 on March 27, 2023 at 10:27 a.m. stated he was scratching the area and bleeding for past two days, he stated he did not receive any cream or medications to area for over a month. Continued observation of Resident R108 on March 29, 2023 at 2:13 p.m. revealed that the dried scab and open areas were still left open to air. This observation was confirmed by Employee E9, Licensed Practical Nurse. 28 PA. Code 211.12(a)(c)(d)(3)(5)	F 0684		

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F 0684 SS=D	Continued from page 14 Nursing services 28 PA. Code 211.5(f)(g)(h) Clinical records 28 PA. Code 211.9(a)(1)(b)(d) Pharmacy services	F 0684		
F 0688 SS=D		F 0688		

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F 0688 SS=D	Continued from page 15 483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:	F 0688	1. On March 27, 2023, the nurse unit manager revised the physician's order and Resident R155's care plan to enable the order to trigger for the nurse and CNA. On March 27, 2023, the bilateral knee extension splints and multipodus boots were donned and doffed as per physician order. 2. The nurse unit manager performed an audit for all residents with a recommendation for a restorative brace and splint program. All orders and care plans were revised so that the order will trigger for the nurse and CNA. 3. On April 6, 2023, the IDT team, nursing team, and therapy department were educated on providing appropriate treatment and services to increase range of motion and decrease further loss of range of motion. In addition, the therapy department and nursing team will utilize a communication tool to alert the nursing team when a resident is discharged from therapy case load and a restorative brace and splint program is recommended. During morning clinical the therapy	Completion Date: **05/08/2023** Status: **APPROVED** Date: **04/27/2023**

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F 0688 SS=D	Continued from page 16	F 0688	department will alert the nursing team of any resident with an end of therapy date. A communication form will be generated by the therapy team and presented to the nursing team for any resident recommended for a restorative brace and splint program. Once the form is received , the nursing will obtain a physician order and treat according to the recommendation. 4. The DON, NHA, and/or designee will complete weekly audits on residents with a restorative brace or splint program for 4 weeks, monthly audits for 2 months and quarterly audits for 2 quarters. Results of the audits will be reviewed at the Quality Assurance Performance Improvement meeting to determine need for additional audits.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0688 SS=D	Continued from page 17 [illegible]	F 0688		
F 0690 SS=D		F 0690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0690 SS=D	Continued from page 18 483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.	F 0690	1. On 3/29/2023, Resident R326 was assessed and there were no signs or symptoms of complications or infection. On 3/29/2023 the nurse unit manager in-serviced 4th floor nursing staff on foley catheter care. 2.on 3/29/2023 The nursing team audited the electronic health record of all residents with a foley catheter. A visual inspection of the resident's foley catheter was conducted to confirm proper placement and dignity. 3. On April 6, 2023, the IDT team and nursing staff were in-serviced on providing appropriate care and services necessary to prevent complications related to the use of indwelling catheters. 4. The DON, NHA, and/or designee will complete weekly audits on foley catheter care for 4 weeks, monthly audits for 2 months and quarterly audits for 2 quarters. Results of the audits will be reviewed at the Quality Assurance Performance	Completion Date: **05/08/2023** Status: **APPROVED** Date: **04/24/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0690 SS=D	Continued from page 19 This REQUIREMENT is not met as evidenced by:	F 0690	Improvement meeting to determine need for additional audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0690 SS=D	Continued from page 20 Based on observation, staff interview, review of clinical records and review of guidelines from the Centers for Disease Control and Prevention (CDC), it was determined that the facility failed to provide appropriate care and services necessary to prevent complications related to the use of indwelling catheter for one of one resident with urinary catheter. (Resident R326) Findings include: Review of guidelines provided by CDC (CDC - a national public health agency of the United States) available at http://www.cdc,gov/infection/guidelines/cauti/recommendations.htm revealed that "III Proper Techniques for Urinary Catheter maintenance: Maintain unobstructed urine flow." 2. Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor. Review of Resident R326's clinical record revealed that Resident R326 was admitted to the facility on	F 0690		

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F 0690 SS=D	Continued from page 21 March 9, 2023, with diagnoses of Neuromuscular dysfunction of the bladder, Muscle Weakness, Cystostomy Status (presence of a surgically created hole into the bladder). Review of physician's order dated March 9, 2023, revealed an order to Secure suprapubic catheter (a catheter that drains urine from the bladder through a small hole in the belly) tubing with leg strap, Suprapubic Catheter care with soap and water every shift, Suprapubic Catheter 14FR (French), 10 milliliters balloon to bedside drain every shift. Review of Resident R326's Admission MDS (Minimum Data Set- a federally required resident assessment completed at specific interval) dated March 16, 2023, Section C0500 (BIMS-brief interview for mental status) revealed a BIMS score of 13 suggesting that Resident R326 was cognitively intact, Section H 0100 (Appliances) revealed that Resident R326 had an indwelling catheter	F 0690		

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F 0690 SS=D	Continued from page 22 Review of resident R326's care plan for risk for infection initiated on March 10, 2023, revealed the following: Risk for infection or has risk for infection related to suprapubic catheter, wound. Goals: Will develop less UTI's (urinary track infections), Wound Site will be free from s/s of infection. Interventions: Foley catheter care if applicable, monitor for s/s of UTI: foul smelling urine, cloudy urine, sediment, decreased output, Care plan for Alteration in elimination r/t Neurogenic bladder, Suprapubic catheter. Goals: will be/remain free from catheter-related trauma through review date. Intervention: Change Foley catheter as ordered and PRN (as needed), Check placement Foley catheter as needed, check tubing for kinks each shift, Empty Foley catheter bag every shift and PRN, Keep Foley catheter bag below the level of bladder to prevent back flow Observation of Resident R326 on March 27, 2023, at 11:43 a.m. revealed that Resident R326 was	F 0690		

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F 0690 SS=D	Continued from page 23 sitting up on the side of his bed wearing a gown receiving bedside therapy. Further observation revealed that resident had a leg bag full of urine strapped to his leg. Interview with Resident R326 conducted at the time of the observation revealed that the urine leg bag was changed on March 26, 2023. Further, Resident R326 revealed that leg bag was on since March 26, 2023, and that he had it on overnight. Follow-up observation of Resident R326 conducted on March 29, 2023, at 1:01 p.m. revealed that resident R326 was sitting on bed wearing a gown eating his lunch. Interview with Resident R326 revealed that he had the leg bag on overnight. Interview with Director of Nursing on March 29, 2023 at 2:20 p.m. revealed that the staff should have used a regular urine collection bag when resident was in bed and change the bag to a leg bag	F 0690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0690 SS=D	Continued from page 24 when resident is out of bed in a wheelchair. 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services	F 0690		
F 0692 SS=D		F 0692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0692 SS=D	Continued from page 25 483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:	F 0692	1. Resident R25 had a PEG tube placed on November 30, 2022 On 3/31/2023 Resident R151 was assessed by the registered dietician and interventions were implemented. 2. On 4/10/2023 the Registered Dietician (RD) completed a full house audit of clinically significant weight loss/gain for 3 months (Jan, Feb, March) to ensure that all clinically significant weight changes were addressed in the clinical record (PCC). 3. On 4/6/2023 the IDT team, nursing staff and dietician were educated by the nurse educator on developing and implementing interventions to address a significant weight loss in a timely manner. The RD and the weight team will meet to review monthly weights for significant changes and discrepancies. The RD will report on significant changes to the IDT weekly. 4. The DON, NHA, and/or designee	Completion Date: **05/08/2023** Status: **APPROVED** Date: **04/24/2023**

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F 0692 SS=D	Continued from page 26	F 0692	will complete weekly audits on residents identified to be at risk for nutrition for 4 weeks, monthly audits for 2 months and quarterly audits for 2 quarters. Results of the audits will be reviewed at the Quality Assurance Performance Improvement meeting to determine need for additional audits.	

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F 0692 SS=D	Continued from page 27 Based on review of facility policy, clinical record review and interview with staff, it was determined that the facility failed to assess, develop and implement interventions to address a significant weight loss in a timely manner for two of 38 residents. (Resident R25 and Resident R151) Findings include: Review of Resident R25's clinical record revealed that Resident R25 was admitted to the facility on May 20, 2015, with current diagnoses of Gastrostomy Status, Malignant Neoplasm of the Prostate, Dementia (progressive disease of the brain), Gastro-esophageal Reflux Disease (when stomach acid repeatedly flows back into the tube connecting your mouth and stomach), Viral Hepatitis (inflamation of the liver). Review of Resident R25's weight records revealed that on October 3, 2022, Resident R25's weight was 157.2 pounds and on November 4, 2022 it	F 0692		

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F 0692 SS=D	Continued from page 28 was 146 pounds. Calculations revealed a 7.2% weight loss. Continued review of Resident R25's weight record revealedc that on October 3, 2022, Resident R25's weight was 157.2 pounds and on March 24, 2023, it was 131.6 pounds. Calculations revealed a 16.28% weight loss. Further, on Review of Resident R25's physician's orders revealed an order dated November 30, 2022, for the nutritional supplement Health Shakes three times a day for promote weight goal 3x/day (breakfast, AM and PM snack), honey thick, record amount consumed. Further review of Resident R25's clinical record revealed no documented evidence that interventions to prevent weight loss were implmented until November 30, 2022. Interview with Registered Dietician, Employee E3 conducted on March 30, 2023, at11:21 a.m.	F 0692		

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F 0692 SS=D	Continued from page 29 revealed that she was aware that the resident was losing weight and resident was evaluated by the speech therapist for dysphagia. Further Employee E3 revealed that during the first episode of weight loss in November 2022, she calculated the resident's weight loss based on the November 9, 2022, weight of 148.9 pounds which was a 5% weight loss because the November 9, 2023, weight was a reweight from the November 4 weight (146 pounds) weight loss. Further interview with Registered Dietician, Employee E3 confirmed that re-weight should have been done immediately when the weight loss was identified on November 4, 2022. Interview with Director of Nursing and Assistant Director of Nursing, Employee E10 revealed that a re-weigh is immediate done after a significant weight difference is noted from the previous weight. Review of weight documentation for Resident R151 revealed that on on January 6, 2023, the resident	F 0692		

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F 0692 SS=D	Continued from page 30 weighed 159.0 pounds.. On March 7,2023, the resident weighed 140.0 pounds which is a -11.95 % loss in two month. Further review of weight documentation revealed that on November 13, 2022, the resident weighed 165.8 lbs. On March 31, 2023, the resident weighed 132.2 pounds which is a -20.27 % loss in six month. There was no documented monthly weight for Resident R151 for the month of February 2023. Review of care plan for Resident R151 dated November 12, 2022 revealed that the resident was at risk for nutritional problem related to poor oral intake and and increased needs as evidenced by varied intake and significant weight loss, stage 4 (ulcer involving loss of skin layers, exposing muscle and bone) sacral pressure ulcer, and unstagable right buttocks pressure ulcer. Review of clinical record for Resident R151 revaled no documented evidence that the resident was assessed and/or interventions were by the	F 0692		

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F 0692 SS=D	Continued from page 31 Registered dietician or the physician for the weight loss documented on March 7, 2023. Interveiw with the Registered dietician, Employee E3 on March 31, 2023 at 11:30 a.m. confirmed that Resident R151 was not assessed by the dietician or physician for weight loss in a timely manner. 28 Pa. Code 211.12(c)(d)(1)(3)(4)(5) Nursing services 28 Pa. Code 211.11(a)(b)(c)(d)(e) Resident care plan 28 Pa. Code 201.18(a)(b)(1)(3) Management	F 0692		
F 0695 SS=D		F 0695		

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F 0695 SS=D	Continued from page 32 483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 0695	1. On 3/28/2023, the 4th floor unit manager assessed Resident R155, and her vitals were within normal limits. Resident did not have an adverse effect to being on 4.5L of oxygen. The unit manager obtained a physician's order to change the oxygen level to 4.5L. On March 28, 2023, the unit manager assessed Resident R110. There were no signs or symptoms of Resident R110 having an adverse effect to being on 4.5L of oxygen. Resident R110's oxygen level was adjusted and set to 5L (this was the original order) as per physician order. On March 30, 2023, the unit manager assessed Resident R139. There were no signs or symptoms of Resident R139 having an adverse effect because of the concentrator being turned off. The concentrator was turned on and oxygen was administered to Resident R139 as per physician orders. 2. On March 30, 2023, the nursing team conducted an audit for all residents with orders for oxygen and/or tracheostomy care to verify	Completion Date: **05/08/2023** Status: **APPROVED** Date: **04/24/2023**

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F 0695 SS=D	Continued from page 33	F 0695	that oxygen was being administered as per physician orders. 3. On April 6, 2023, the IDT team and nursing team were in-serviced by the nurse educator on providing residents with appropriate respiratory care and following physician orders. In addition, a physician order was obtained monitor all tracheostomy and oxygen units for proper functionality hourly. 4. The DON, NHA, and/or designee will complete weekly audits on residents with oxygen or a tracheostomy for 4 weeks, monthly audits for 2 months and quarterly audits for 2 quarters. Results of the audits will be reviewed at the Quality Assurance Performance Improvement meeting to determine need for additional audits.	

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F 0695 SS=D	Continued from page 34 Based on observation, staff interview, review of facility policy and review of clinical record, it was determined that the facility failed to provide residents with appropriate respiratory care consistent with professional standards of practice for three of three residents with tracheostomy and oxygen. (Resident R155, Resident 110 and Resident R139) Findings include: Review of undated Oxygen Administration Policy revealed that under section "Policy": Oxygen is administered to residents who need it, consistent with professional standards of practice, at comprehensive person-centered care plans, and the resident's goals and preferences. Under section "Policy explanation and Compliance Guidelines": 1. Oxygen is administered under orders of a physician, except in the case of an emergency. Review of Resident R155's clinical record revealed that Resident R155 was admitted to the facility on	F 0695		

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F 0695 SS=D	Continued from page 35 January 17, 2023 with diagnoses of Chronic Respiratory Failure with Hypoxia (a condition that occurs when the lungs cannot get enough oxygen into the blood), Anoxic Brain Damage (brain damage caused by a complete lack of oxygen to the brain) and Tracheostomy Status (the presence of a surgically created hole in the windpipe that provides an alternative airway for breathing), Observation of Resident R155 conducted during the tour of the 4th floor unit on March 27, 2023, at 11:26 a.m. revealed that Resident R155 was receiving oxygen via tracheostomy collar. Further observation revealed that the oxygen concentrator flow meter reading at eye level was at 4.5 liters/minute. Further observation revealed that the oxygen tubing was not dated. Review of physician orders for Resident R155 revealed an order for oxygen to be set at 6 liters / minute Observation of Resident R110 on March 27, 2023,	F 0695		

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F 0695 SS=D	Continued from page 36 at 10:52 a.m. revealed that Resident R110 was on oxygen via tracheostomy collar. Further observation revealed that the oxygen concentrator flow meter reading at eye level was at 4 liters/minute. Review of physician orders for R110 revealed an order of 5 liters/minute via trach collar. Follow-up observation of Resident R155 conducted on March 28, 2023, at 12:49 p.m. revealed that the oxygen concentrator flow meter reading at eye level was at 4.5 liters/minute. Interview with Licensed nurse, Employee E11 conducted at the time of the observation confirmed that Resident R155's oxygen was at 4.5 liter/min. Review of physician orders for Resident R139 dated October 4, 2022 revealed an order to administer continuous oxygen at 2 Liters/minute via trach Observation of Resident R139 on March 30, 2023	F 0695		

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F 0695 SS=D	Continued from page 37 at 2:28 p.m. revealed that the resident had a tracheostomy tube for respiratory support. Residents tracheostomy was connected to a compressor and oxygen concentrator. Further observation revealed that the oxygen concentrator was not turned on and it was showing "0" reading. This was confirmed by Licensed Nurse. Employee E31, 28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services	F 0695		
F 0697 SS=D		F 0697		

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F 0697 SS=D	Continued from page 38 483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 0697	1. On March 31, 2023, Resident R100's care plan was revised to include non-pharmacological interventions as an alternative to pain medication. 2. On March 31, 2023, the nursing team audited the electronic health record of all residents on a PRN medication for pain. The care plans for those residents were revised to include non-pharmacological interventions as an alternative to pain medication. 3. On 4/6/2023 the IDT team and nursing staff were in-serviced by the nurse educator on offering residents alternative methods to manage pain before administering pain medications. Prior to administering a PRN medication licensed nurses will offer a non-pharmacological alternative consistent with the resident's care plan. 4. The DON, NHA, and/or designee will complete weekly audits on residents receiving PRN pain	Completion Date: **05/08/2023** Status: **APPROVED** Date: **04/24/2023**

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F 0697 SS=D	Continued from page 39	F 0697	medications for 4 weeks, monthly audits for 2 months and quarterly audits for 2 quarters. Results of the audits will be reviewed at the Quality Assurance Performance Improvement meeting to determine need for additional audits.	

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F 0697 SS=D	Continued from page 40 Based on review of facility policy, review of clinical records, and interview with staff and residents, it was determined that the facility failed to implement non-pharmacological interventions in accordance with professional standards for one of 38 residents reviewed (Resident R100). Findings include: Interview with Resident R100 on March 27, 2023, at 10:05 a.m. revealed that he was experiencing pain at a level of 6 on a scale of 0 to 10. He stated he had many fractures and surgeries which was the reason for his pain. Resident stated he took Tylenol (it can treat minor aches and pains) and Ibuprofen (It can treat fever and mild to severe pain) but the pain was still at a level of 6. Resident also stated he was not receiving any non-pharmacological pain management. Review of Resident R100's clinical record revealed the resident was admitted to the facility on March 9, 2021, and had diagnoses including fracture of upper	F 0697		

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F 0697 SS=D	Continued from page 41 and lower end of left fibula. Fracture of left tibia, acute compartment syndrome (A painful and dangerous condition caused by pressure buildup from internal bleeding or swelling of tissues), osteogenesis (a genetic or heritable disease in which bones fracture (break) easily, often with no obvious cause or minimal injury), and fracture of lower extremity. Review of Resident R100's care plan revised March 9, 2021, revealed the resident was at risk for acute pain related to the fracture with interventions included, anticipate resident's need for pain relief and respond immediately to any complaint of pain, notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain, provide non-pharmacological interventions. Review of physician orders for Resident R100 dated December 27, 2021, revealed an order for Methadone 200 mg every day in the morning for opioid dependance.	F 0697		

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F 0697 SS=D	Continued from page 42 Review of clinical record for Resident R100 revealed no documented evidence that the resident was offered or received non-pharmacological interventions according to his care plan. Interview with Director of Nursing, Employee E2, on March 31, 2023, at 11:00 a.m. confirmed that Resident R100 was not receiving any non-pharmacological interventions and stated staff should attempt non-pharmacological interventions prior to administering pharmacological interventions. 28 Pa. Code 211.5(f) Clinical records 28 Pa. Code 211.10(c) Resident care policies 28 Pa Code 211.12(c) Nursing services 28 Pa Code 211.12(d)(3)(5) Nursing services	F 0697		

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F 0740 SS=J		F 0740		

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F 0740 SS=J	Continued from page 44 483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by:	F 0740	1. On 3/17/2023 Resident R154 was moved to the 4th floor and Resident A.K. was moved closer to the nursing station on West Wing. The reason for the move was to separate the two residents and to increase the visibility of Resident A.K. On 3/21/2023, Cheltenham Nursing and Rehab reviewed all resident's electronic health record and identified a list of residents with a diagnosis of substance use disorder. On 12/21/2022 Cheltenham Nursing and Rehab conducted education for facility staff on CMS's implementation of Phase 3, dealing with Behavioral Health and Substance Use Disorder. On January 26, 2023, during QAPI, Cheltenham Nursing and Rehab reviewed and approved new policies and procedures for residents with mental health diagnosis and substance use disorder. On 4/12/2023 the NHA reviewed transportation logs and interviewed Resident R154 and DON and verified that Resident R154 did not attend the methadone clinic without an	Completion Date: **05/08/2023** Status: **APPROVED** Date: **04/24/2023**

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F 0740 SS=J	Continued from page 45	F 0740	escort. On 4/20/2023 both Resident R 154 and Resident R141 signed behavioral health contracts relating to substance use and unprescribed medications. Interventions specific to Resident R154 include January 24,2023 facility spoke with Methadone clinic to inform the clinic of the drug transaction that occurred at their location. On January 24, 2023, Maintenance team secured the window outside of Resident R154.'s room to eliminate the possibility of narcotics being supplied through his window. On January 24, 2023, Resident agreed to allow the staff to search his belongings when he returns from an outing or has a delivery sent to the facility. On January 24, 2023, Resident R154. informed the NHA that he wanted to start attending NA meetings again. On, 3/17/2023 NHA and DON spoke with the Medical Director of the Methadone Clinic and got approval for a facility staff member to pick-up take home bottles of Methadone in	

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F 0740 SS=J	Continued from page 46	F 0740	order to limit his ability to have access to obtain narcotics. On 3/17/2023 the Medical Director of Cheltenham wrote an order to restrict Resident R154. from going on leave of absence and outings. The Medical Director deemed Resident R154. unsafe to go into the community alone. On 3/20/2023 the facility sent a referral to Eagleville Drug and Alcohol Rehab. 2. On 3/27/2023, the nurse management team and social services staff conducted an audit of all residents with a diagnosis of substance use disorder. Person centered care plans were implemented for each resident relating to substance use disorder. 3. On 3/28/2023 the facility started training facility staff on identifying residents with possible drug abuse history and developing and implementing interventions to prevent residents access to unprescribed drugs. The facility has educated 100% of the current active staff. Staff on a leave of absence or FMLA will be educated upon return	

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F 0740 SS=J	Continued from page 47	F 0740	to active duty. 4. The DON,NHA and/or designee will complete weekly audits of new admissions and current residents with a history of substance use for 3 months. Audits will be reviewed at the Quality Assurance Performance Improvement meeting.	

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F 0740 SS=J	Continued from page 48	F 0740		

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F 0740 SS=J	Continued from page 49 28 Pa Code 211.12 (d) (5) Nursing Services	F 0740		
F 0755 SS=D		F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHELTENHAM NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **032202**	**600 WEST CHELTENHAM AVENUE PHILADELPHIA, PA 19126**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0755 SS=D	Continued from page 50 483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 0755	1. On 3/31/2023 the nurse management team audited all controlled drugs on the 3rd and 4th floor. All controlled drugs were accounted for. 2. On 3/31/2023 the nurse management team audited all controlled drugs on all units to verify that all controlled drugs were present and accounted for. 3. On 4/6/2023 the IDT team and nursing licensed nursing staff were in-serviced by the nurse educator on developing a system to accurately reconcile the receipt and disposition of controlled substances. The facility has implemented narcotic control books on all units that were provided by the facility's pharmacy partner. 4. The DON, NHA, and/or designee will complete weekly audits for 4 weeks, monthly audits for 2 months and quarterly audits for 2 quarters. Results of the audits will be reviewed at the Quality Assurance Performance Improvement meeting.	Completion Date: **05/08/2023** Status: **APPROVED** Date: **04/24/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0755 SS=D	Continued from page 51 This REQUIREMENT is not met as evidenced by:	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0755 SS=D	Continued from page 52 Based on a review of facility documents, observations, and interviews with staff, it was determined that the facility did not establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation for two of two units observed (fourth floor and third-floor nursing units). Findings include: Review of facility policy on Ordering and Receiving Controlled Medication dated January 2020 revealed that under section "Policy:" Medication included in the Drug Enforcement Agency (DEA) classification as controlled substances, and medications classified as controlled substances by state law are subject to special ordering, receipt, and record keeping requirements in the nursing care center in accordance with federal and state laws and regulations. Under section "Procedures", 1. The Director of Nursing and the Consultant Pharmacist monitors for compliance with federal and state laws and regulations in the handling of controlled	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHELTENHAM NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **032202**	**600 WEST CHELTENHAM AVENUE PHILADELPHIA, PA 19126**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0755 SS=D	Continued from page 53 medications. 2. Medications listed under schedules II, III IV and V are dispensed by the pharmacy in readily accountable quantities and containers designed for easy counting of contents. 3. The pharmacy or the nursing care center prepares an individual resident controlled substance record/receipt/log for each controlled substance medication prescribed for a resident as applicable per state law. This log is placed in the medication administration record or the narcotic book to be counted every shift. Review of the facility Shift to Shift Narcotic accountability record review conducted on March 29, 2023, at 8:49 a.m. with licensed practical nurse, Employee E6, on the fourth-floor unit revealed that, the Narcotic accountability record only accounted for the count of the controlled substances present at the time of the count but did not account for the individual resident controlled substance record/receipt/log for each controlled substance medication prescribed for a resident dispensed by the pharmacy and stored in the narcotic boxes.	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395330	A. BLDG: __00_____ B. WING: _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHELTENHAM NURSING AND REHABILITATION CENTER	**600 WEST CHELTENHAM AVENUE PHILADELPHIA, PA 19126**
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F 0755 SS=D	Continued from page 54 Interview with Employee E6, LPN, revealed that the in-coming and out-going licensed nurses were signing for the controlled substances present in the narcotic box and their corresponding narcotic count sheets in the narcotic binder at the time of the count. Further, Employee E6 confirmed that if an entire set of controlled substance and its corresponding Narcotic count sheet was missing, there was no system in place to account for that missing set of controlled substance and that if a set of Narcotics was missing together with its corresponding Narcotic count sheet, she would not know that the narcotics were missing until the time that the narcotic was to be administered to the resident because she would not have not known that the narcotic was in the bin at the time of the shift to shift count. Review of the Shift-to-shift Narcotic Accountability record review conducted on March 29, 2023, at 9:50 a.m. with Nurse Manager, Employee E7, on the third-floor unit revealed that there were missing signatures. Further, the Narcotic accountability record on the third-floor unit only accounted for the	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHELTENHAM NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 032202	600 WEST CHELTENHAM AVENUE PHILADELPHIA, PA 19126

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F 0755 SS=D	Continued from page 55 count of the controlled substances present at the time of the count but did not account for the individual resident-controlled substance record/receipt/log for each controlled substance medication prescribed for a resident dispensed by the pharmacy and stored in the narcotic boxes. Interview with Employee E7 revealed that the in-coming and out-going licensed nurses were signing for the controlled substances present in the narcotic box and their corresponding narcotic count sheets in the narcotic binder at the time of the count. Further, Employee E7 confirmed that if an entire set of controlled substance and its corresponding Narcotic count sheet was missing, there was no system in place to account for that missing set of controlled substance. Interview with Employee E2, DON, on March 29, 2023, at 02:20 p.m. confirmed that the facility did not have a system in place to account for the individual narcotic in the narcotic bins and that there was no tracking system to account for a set of	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395330	A. BLDG: 00 B. WING:	03/31/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHELTENHAM NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **032202**	**600 WEST CHELTENHAM AVENUE PHILADELPHIA, PA 19126**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0755 SS=D	Continued from page 56 missing controlled substance and its corresponding narcotic count sheet. 28 Pa. Code 211.9(a)(1)(k) Pharmacy services 28 Pa. Code 211.12(a)(c)(d)(1)(3)(5) Nursing services	F 0755		
F 0758 SS=D		F 0758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0758 SS=D	Continued from page 57 483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 0758	I. On 3/31/2023 the nurse manager reviewed the electronic medical record for Resident R126. Resident R 126 was assessed by the physician and an order was obtained to change the medication from PRN to routine. II. On 3/31/2023, the Unit Managers reviewed all residents receiving psychotropic medications to verify that supporting physician documentation was present. III. On 4/6/2023, the Staff Development Coordinator in-serviced the licensed nurses on the documentation requirements for psychotropic medications, including documenting the rationale for the use of psychotropic medications and duration of the therapy. IV. The Director of Nursing, Assistant Director of Nursing, Unit Managers and/or Social Service staff will complete an audit of residents receiving PRN psychotropic medications weekly for four weeks, then monthly for two months.	Completion Date: **05/08/2023** Status: **APPROVED** Date: **04/24/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0758 SS=D	Continued from page 58 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:	F 0758	Results of the audits will be reviewed at the Quality Assurance Performance Improvement meetings for revisions as needed and to determine need for additional audits.	

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F 0758 SS=D	Continued from page 59 Based on clinical record review and staff interview, it was determined that the facility failed to ensure resident's medication regimen was free from potentially unnecessary medications for one of five residents reviewed (Resident R126). Findings include: Review of physician orders for Resident 126's dated June 28, 2022, revealed an order for Ativan 0.5 mg via mouth every 6 hours as needed for generalized anxiety disorder. Review of Medication Administration Record revealed that the resident received the Ativan 0.5 mg as needed order 32 times in the month of March 2023. Review of clinical record for the month of March 2023 revealed no documented rationale for Resident R126 receiving Ativan 0.5mg as needed order.	F 0758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0758 SS=D	Continued from page 60 Review of Medication Administration Record revealed that the resident received the Ativan 0.5 mg as needed order 32 times in the month of February 2023. Review of clinical record for the month of February 2023 revealed no documented for Resident R126 receiving Ativan 0.5 mg as needed order. Review of clinical record did not reveal any evidence that the resident was evaluated by practitioner for continued use of the as needed psychotropic medication and the duration of therapy. Interview with the Director of Nursing, on March 31, 2023, at 11:00 a.m. confirmed that the PRN(as needed) psychotropic medication orders should not be ordered for more than 14 days unless a practitioner evaluates and document the rationale and duration of therapy. 28 Pa. Code 211.12(d)(1) Nursing services	F 0758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0758 SS=D	Continued from page 61 28 Pa. Code 211.12(d)(3) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services	F 0758		
F 0835 SS=D		F 0835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0835 SS=D	Continued from page 62 483.70 Administration §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	F 0835	1. The Administrator and Director of Nursing have reviewed and signed their understanding of their job description requirements on 4/6/2023. 2. On 4/6/2023 the Administrator and Director of nursing were educated by the Quality Assurance Nurse on the responsibilities and accountabilities of their respective positions. These responsibilities include providing adequate behavioral health services for residents with substance use disorders. 3.. The Quality Assurance Nurse will conduct reviews/audits with the Administrator and Director to review/audit resident behavioral health care plans and documentation weekly for two months. Results of the audits will be reviewed at the Quality Assurance Performance Improvement meetings to determine need for additional audits.	Completion Date: **05/08/2023** Status: **APPROVED** Date: **04/24/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0835 SS=D	Continued from page 63 Based on review of clinical records, facility documentation, review of job description and interviews with staff, it was determined that the Nursing Home Administrator and Director of Nursing failed to effectively manage the facility related to ensuring that two residents received behavioral services for substance use disorder to prevent access to unprescribed medications for two of 38 residents reviewed. (Residents R141 and R154) Findings include: A review of the job description for the Nursing Home Administrator revealed that the administrator was responsible for all activities and departments in the center to assure that the highest degree of quality of care was consistently provided to all of	F 0835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0835 SS=D	Continued from page 64 the residents. The administrator was also responsible to ensure that proper health care services was provided for all residents by implementing rules and regulations promoted by government agencies. A review of the job description for the Director of Nursing revealed that the Director of Nursing was responsible for the administration of nursing services in the center. The Director of Nursing was responsible for directing the professional nursing and nursing personnel in rendering resident care; while ensuring compliance with policies and regulations governing nursing care of residents. The Director of Nursing was responsible for reviewing nursing progress notes to ensure that documentation and nursing care were being implemented in accordance with the	F 0835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0835 SS=D	Continued from page 65 resident's plan of care. The Director of Nursing was responsible for ensuring a formal liaison between the medical staff and the nursing department. Review of Resident R141's nursing note dated January 23, 2023, at 2:59 p.m, revealed "Resident noted to be more sleepier than normal. Resident unable to be woken up easily. Resident admitted to taking medication. Resident states she brought a Percocet 30 mg (milligrams). Resident was able to be woken up after hard sternum rubs. Resident was encourage to go to the hospital. Resident refused to go to the hospital." Interviews conducted with Nursing Home Administrator and Director of Nursing on March 28, 2023, at 1:00 p.m. confirmed that there was no investigation conducted	F 0835		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0835 SS=D	Continued from page 66 by the facility related to how the resident was able to obtain the narcotic medication Percocet. Further, it was confirmed during interview that there was no person centered care planning or behavioral contract established with Resident R141 to protect the resident from substance use and abuse. Review of Resident R141's nursing documentation dated March 16, 2023, at 7:30 p.m. by Licensed nurse, Employee E31 revealed that approximately at 6:40 p.m. Employee E31 was called to assess Resident R141. The nursing supervisor was informed by the charge nurse that Resident R154 had told the charge nurse that Resident R141 was in his room and had overdose on something he gave her. "Upon assessing resident, resident was noted with slow shallow breathing, cold	F 0835		

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	395330	A. BLDG: 00 B. WING:	03/31/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
CHELTENHAM NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: **032202**	**600 WEST CHELTENHAM AVENUE PHILADELPHIA, PA 19126**

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F 0835 SS=D	Continued from page 67 and clammy skin and slow pulse. When asking [Resident R154] what happened, he stated she came to him because she was in pain and according to [Resident R154] gave her some narcotics including Percocet 30 mg and then began to become unresponsive. 2 doses of Narcan given to resident via alternating nostrils. 911 (Emergency Medical Services) called for transportation to ER (Emergency Room) for evaluation. DON/MD (medical doctor) made aware. Resident became more alert and responsive appx. 5-10 minutes after Narcan administration." Continued review of nursing documentation revealed a nursing note dated March 16, 2023, at 9:02 p.m. which noted that Resident R154 came to the nurse to report that Resident R141 overdose in his room. Resident R154 was	F 0835		

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F 0835 SS=D	Continued from page 68 asked what Resident R141 had taken and how did she get it. Resident R154 said she asked him to get her some Heroin and Oxycodone which he did when he went out on a leave of absence. A review of Resident R141's hospital record dated March 16, 2023, revealed that this resident was treated for an opioid overdose. The hospital record indicated that Resident R141 was evaluated after opioid overdose and that emergency care with Narcan was administered to Resident R141. The hospital emergency department staff discharged Resident R141 on March 16, 2023; to return to the nursing facility for further observation and monitoring. Review of Resident R154's nursing note dated January 24, 2023, at 12:03 a.m. revealed that at approximately 5:45 p.m. nurse was alerted by CNA (nurse aide)	F 0835		

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F 0835 SS=D	Continued from page 69 that resident was slumped over on his wheelchair and has not touched dinner tray. This nurse came into room to assess resident, HR (heart rate) 50 RR (respirations) 16 Sp02 (oxygen level) 94% at room air. Nurse was unable to obtain B/P (blood pressure). Resident R154 unable to be aroused. made UM (unit manager) aware. UM attempted to arouse resident also noted ineffective. Nursing supv. (supervisor) made aware, resident responding briefly to nsg (nursing) supv. Resident appeared to be suffering from overdose recommended that Narcan be admin (administer). 2 doses of Narcan adm. 3 minutes apart 1 in each nostril." Resident R154 was sent to local hospital via 911 (Emergency Medical Services). Resident R154 returned to the facility on January 24, 2023.	F 0835		

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F 0835 SS=D	Continued from page 70 Review of hospital emergency department discharge notes dated January 23, 2023, revealed a diagnosis of Opioid dependence, Opioid withdrawal, and Opioid overdose. Further review of Resident R154's documentation dated January 24, 2023 at 7:55 p.m. revealed that Nursing Home Administrator (NHA) and Director of Nursing (DON) interviewed Resident R154 and Resident R154 admitted to NHA and DON that he bought a pill from someone outside of the clinic while getting his methadone treatment. Review of Resident R154's care plan revealed that a care plan for the potential for opioid overdose was not initiated until March 17, 2023. Further, Resident R154's behavior of supplying drug to another	F 0835		

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F 0835 SS=D	Continued from page 71 resident was not addressed in the care plan until on March 29, 2023 Further review of Resident R154's clinical record revealed that there was no documented evidence that Resident R154 was monitored after returning from a methadone clinic for the procession of unprescribed medications. Further, there was no evidence that toxicology tests were offered/conducted on Resident R154 after he was observed exhibiting signs and symptoms of drug use on January 23, 2023, February 9, 2023, and March 16, 2023. Interviews with Facility Administrator and Director of Nursing conducted on March 28, 2023, at 1:00 p.m. confirmed that resident admitted to them that he purchased the pills from someone at the	F 0835		

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F 0835 SS=D	Continued from page 72 methadone clinic. Further interview with NHA and DON also confirmed that there was no behavioral contract established with Resident R154 to address both his substance use and giving unprescribed narcotic to Resident R141. Based on the deficiencies identified in this report, the Nursing Home Administrator and Director of Nursing failed to fulfill essential duties and responsibilities of their position, contributing to the Immediate jeopardy situation. Refer to F740 28 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code 201.18(b)(1) Management	F 0835		

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F 0835 SS=D	Continued from page 73 28 Pa. Code 201.18(b)(2) Management 28 Pa. Code 201.18(e)(1) Management 28 Pa Code 201.29 (c) Resident rights 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1) Nursing services	F 0835		
F 0925 SS=E		F 0925		

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F 0925 SS=E	Continued from page 74 483.90(i)(4) Maintains Effective Pest Control Program §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by:	F 0925	I. On, 3/27/2023 the kitchen floor was thoroughly cleaned including underneath the large commercial cooking equipment. The wall and floor behind the juice machine were cleaned. The dry storage was cleaned, and plastic racks and electrical warming equipment were removed from the floor. The debris and sludge like material was removed. The grease identified on the wall behind the hot food service equipment was removed. On, 4/20/2023 Maintenance repaired the wall under the 3-compartment sink and dish machine. On 3/27/2023 the office located inside the kitchen was cleaned and a contractor has been contacted to repair the office wall. On 3/27/2023 the items and debris in the janitor's closet were removed. On 3/28/2023 the doors on the West wing and in the service hallway were repaired. The service corridor was cleaned, and debris removed on 3/28/2023. The maintenance department patched the holes and Pest control was contacted, and area treated the kitchen, conference area	Completion Date: **05/08/2023** Status: **APPROVED** Date: **04/24/2023**

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F 0925 SS=E	Continued from page 75	F 0925	and service hallway on 3/27/2023. II. Dietary floors have been checked, cove base intact. Food storage areas were checked/cleaned. Steamtables, ceiling tiles, vents, light/ceiling fixtures, walls and carts have been checked and cleaned. Revised sanitation check list is being completed. Doors and door frames have been checked for holes and/or openings that can serve as potential breeding grounds for pests. III. Cleaning schedules, sanitation checks, pest control schedules, preventive maintenance logs have been reviewed and revised for the dietary department. The Dietary Service Manager, dietary staff and maintenance staff have been educated by the NHA on dietary sanitation requirements, use of the revised schedules/logs, and timely notification of maintenance and pest control issues on 4/6/2023. IV. The Dietary Service Manager, Maintenance Supervisor, Administrator, Assistant Administrator and/or Designee will complete audits of dietary sanitation,	

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F 0925 SS=E	Continued from page 76 Based on observation, review of the facility's [illegible] 28 Pa. Code 211.10(a) Resident care policies	F 0925	pest control and preventive maintenance weekly for 4 weeks, monthly for 2 months, and then quarterly for 2 quarters. Results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed to determine need for additional audits.	

Certified End Page

CHELTENHAM NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 032202

SURVEY EXIT DATE: 03/31/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Acting Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

THIS IS A CERTIFICATION PAGE

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